

Medically Vulnerable People (MVP) Interim Housing Program Report January 21, 2025

Quarter 4

October 2024 – December 2024



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HOMELESSNESS HURTS. HEALTH CARE HELPS.



Why is the MVP program needed?



Number of seniors age 62+ experiencing homelessness is rising so MVP Interim Housing is critical



Individuals experiencing homelessness with chronic health conditions is prevalent in overall population



Housing and health care work together to help individuals to prevent a return to homelessness



Health conditions and injury can cause a person to experience homelessness, especially the aging population, and may delay recovery



Address an immediate gap of supportive care for this especially vulnerable population



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2024 Year End Updates

2024 Impact

- 388 individuals served, ranging in age from **31** to **86**, with an average age of **62**
- **26** moves to permanent housing or long-term care
- Ongoing collaboration with **Sandy Police** and **Fire**
- Connections to community resources through referral partners and growing attention on senior homelessness



Lessons Learned

- Safety protocols – continuing to adapt and respond
- Balance of medical care needs with housing priorities
- Improved intake procedures & pre-admission screenings
- Supporting our senior clients truly takes a community

2025 Vision

- Senior Homelessness Task Force
- Additional strategic partnerships
- More facility improvements
- Increase positive client health and housing outcomes



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Community Engagement

Volunteerism

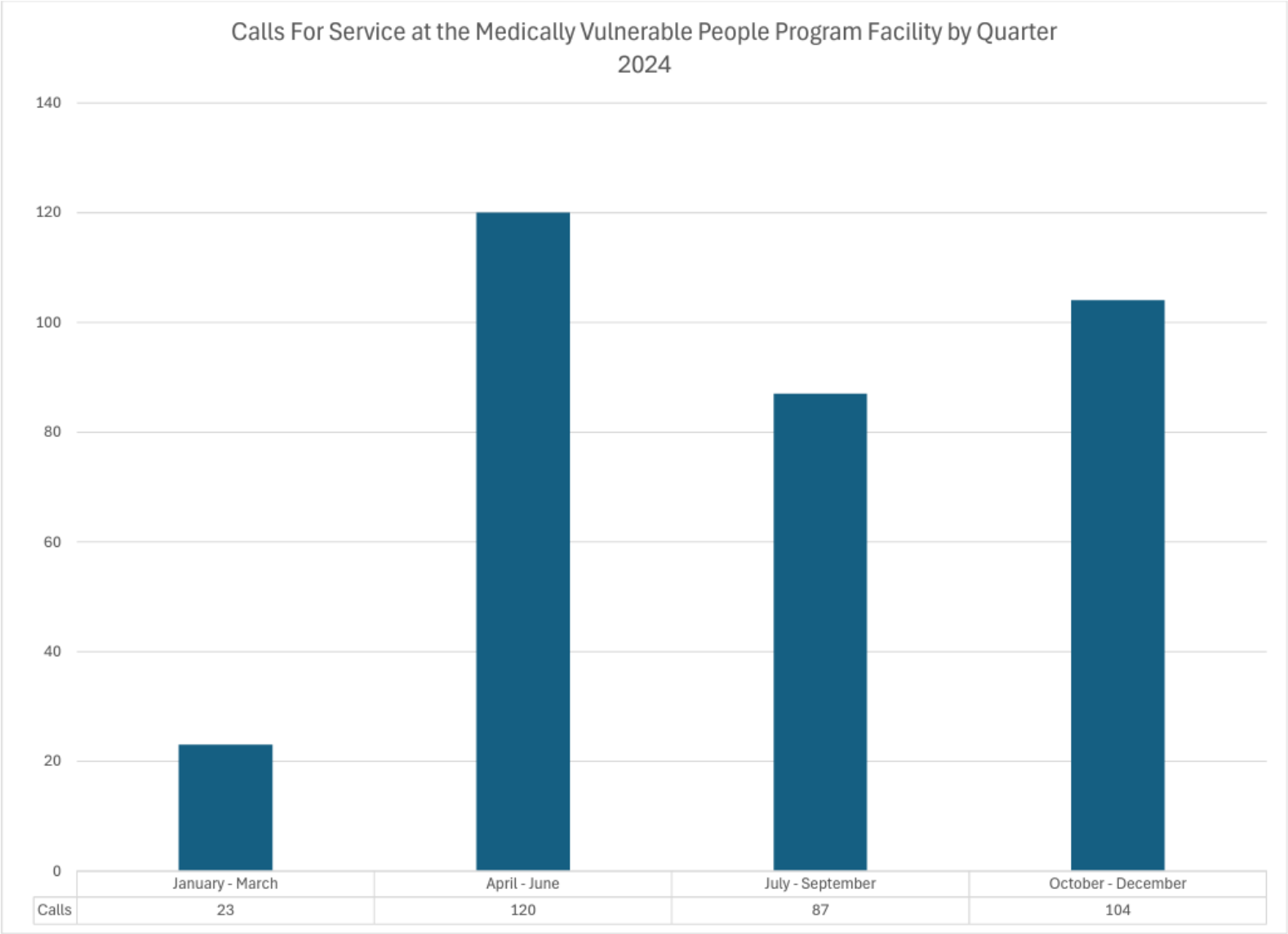
- There are several ways to get involved at MVP!
 - Group activities with clients
 - Donation drives for specific needs
 - Meal delivery for lunch and dinner
- Email volunteers@theroadhome.org for more info



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Sandy Police Data



Fourth Street Clinic Patient Care Overview

- Consistent mobile and on-site primary care clinics.
 - 1 Day a week with Mobile
 - 1 Day a week with Physician using the on-site clinic
- EMT services have increased hours on site
 - Monday-Friday 6:00 AM – 12:00 AM
- Pharmacist is seeing diabetic patients with elevated A1C's to provide diabetes management and counseling
- Pharmacy medication reconciliation appointments assist patients with complex medication management and compliance. Offering appointments twice per month.



- Nursing services are available to all FSC patients
- Medical Case Management is offered to all individuals at MVP
- Transportation support ensures that patients get to referral appointments
- Onsite Therapist helps patients address challenges with mental health and substance use disorders
- Point-of-care lab testing is available to all FSC patients. More complex lab analyses have been arranged through ARUP.
- Additional onsite services include
 - Home Health
 - Physical Therapy
 - Oxygen monitoring
 - Wheelchair repair

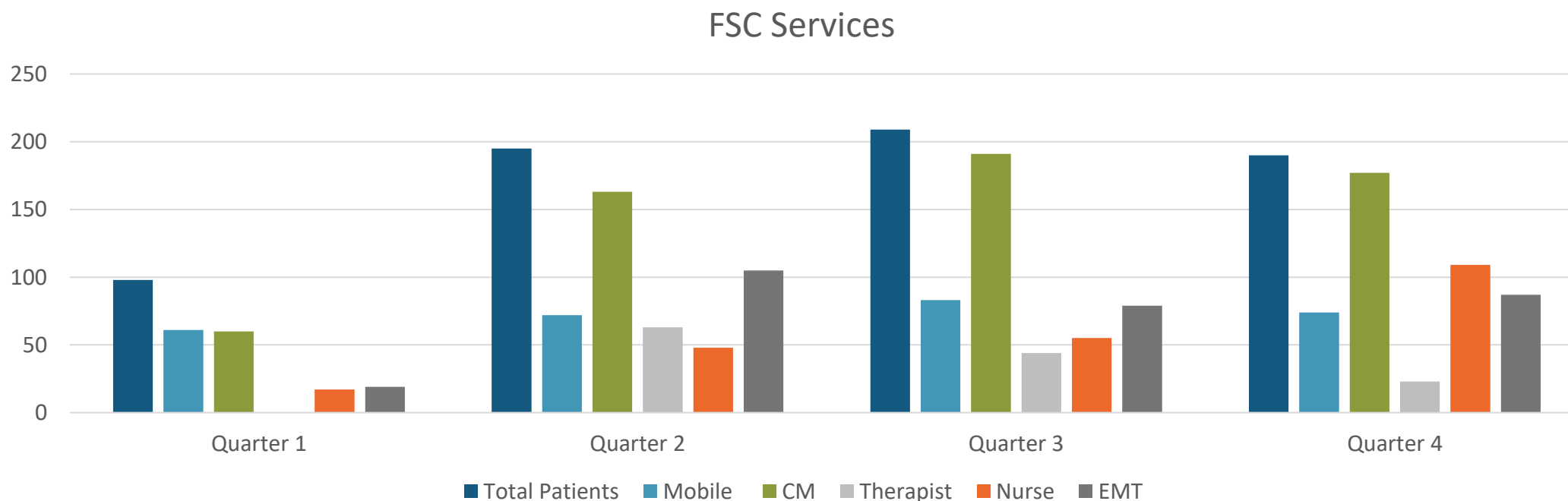


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Fourth Street Clinic Patient Care Overview

6,148 visits provided to 339 patients

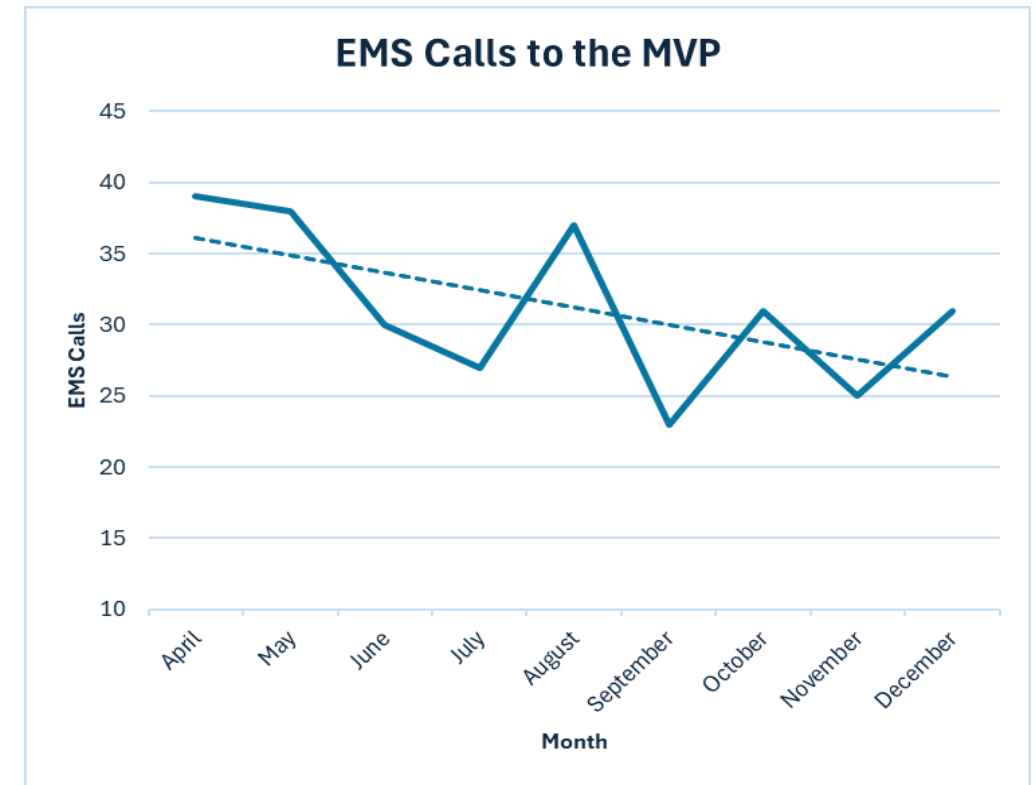
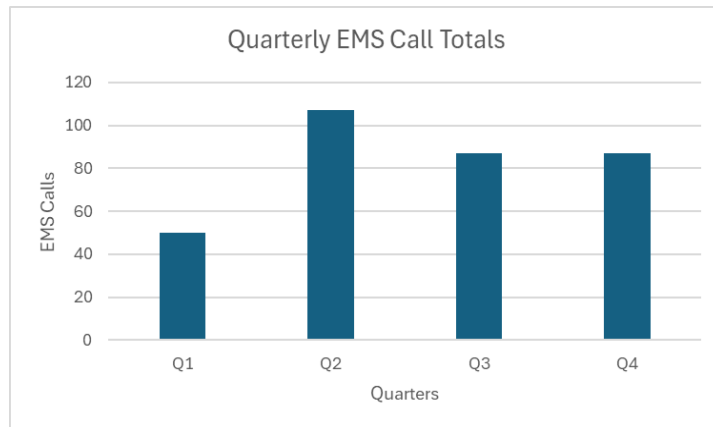


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Fourth Street Clinic EMT Services & Calls to EMS

- FSC EMT swing shift started 8/26/24
- Maintained 19% drop from Q2 peak



Fourth Street Clinic 2025 Vision

- Stabilize staffing
- Redefine services needed for high acuity
- Increased engagement in behavioral health services
- Continue to refine and add to the medical model



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FSC - Patient Example #1

Patient Example – Male, 68

Challenges:

- Large exostosis causing debilitating foot pain and immobility
- Severe, chronic depression
- Declining vision impairing daily tasks
- Lack of preventative care due to chronic homelessness

Services Provided:

- Case management referrals led to exostosis surgery and follow-up care
- Wound care and oxygen support during recovery
- On-site provider and behavioral health appointments
- Medication management, prescription delivery, and provision of glasses for enhanced vision
- Transportation assistance for appointments

Outcomes:

- Successful surgery resulted in decreased pain and increased mobility
- Patient received a smooth transition to PARC Medical CM and is in the process of being transitioned to The Inn Between for longer term care



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FSC - Patient Example #2

Patient Example – Female, 86 (one of the first MVP patients)

Challenges:

- Severe arthritis, chronic pain, and depression
- Limited mobility and difficulty maintaining independence
- Barriers to accessing coordinated, comprehensive care
- Lack of preventative care due to chronic homelessness

Services Provided:

- Case manager coordinated medical care, including pain management and referrals to audiology, physical therapy, and eye specialists
- Transportation assistance for appointments
- On-site provider and behavioral health appointments as needed
- Assistance in obtaining a service animal for emotional support
- Medication delivery and transportation support

Outcomes:

- Improved physical health, pain management, and mobility
- Enhanced quality of life- companionship of a service animal
- Patient transitioned from MVP to stabilized housing within a local senior center



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Shelter the Homeless

Facility and Security Updates - Q4

- New Configuration for Security at Entrance to Facility
- **Wayfinding Signage** for ease of navigation through facility
- Remote entry lockdown, intercom, Knox Box, additional security cameras
- Installation of **8' Impermeable Fence** to expand exterior courtyard space
- **81,560 hot meals** served in 2024
- Anti-slip surface and new heating/cooling unit in Community Common Room to add comfort and convenience
- New asphalt, ADA stalls, mulch for safety/refreshed exterior appearance



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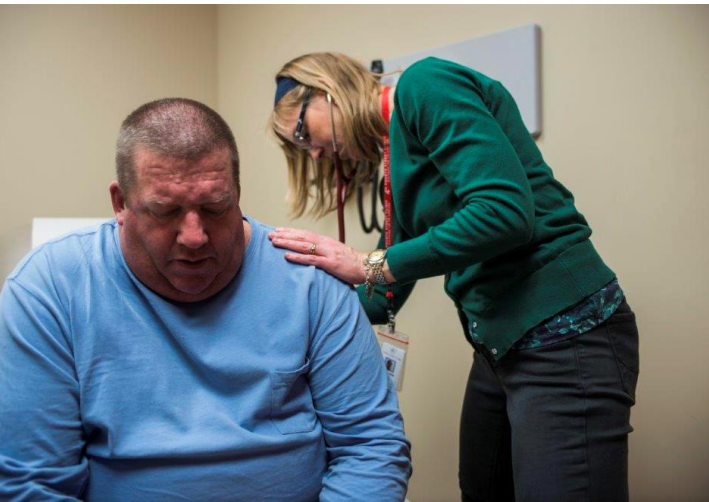
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Thank you.

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